TOWN OF ISLIP

DEPARTMENT OF PARKS RECREATION AND CULTURAL AFFAIRS

FOR OFFICE USE ONLY

NYS #:_____

DR.LICENSE #:_____

DIAG. CODE:_____

Disabled Parking Permit Application

The following is to be completed by the applicant or the applicant's legal guardian or primary care giver. Please note that failure to completely answer ALL of the questions below may result in a delay of issuance of Parking Permit. THE COMPLETED APPLICATION MUST BE AN ORIGINAL.

PLEASE BE INFORMED THAT IT IS NOW A NEW YORK STATE REGULATION THAT YOU MUST PROVIDE A PHOTO COPY OF A VALID NYS DRIVERS LICENSE OR NON DRIVERS I.D. IF YOU ARE NOT IN RECEIPT OF EITHER OF THESE YOU MUST PROVIDE A SIGNED LETTER TO THAT EFFECT.

Name of Disabled Person:

Last: _____ First: _____ Middle: _____

Mailing Address: _____
(Address) (Town) (Zip)

Home Address (if different): _____

Home Phone: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Occupation: _____ Cell or Business Phone: _____

Do you use any of the following?

☐ Crutches ☐ Cane ☐ Walker ☐ Wheelchair

☐ Portable Oxygen ☐ Other: _____

I certify that the above information and the statements contained herein are true. I further acknowledge that I have read and understood the conditions of the application and the disabled parking permit.

_____ _____

Date Signature of Applicant or Primary Care Giver

PLEASE NOTE: **A physician must provide a diagnosis, written on a prescription pad or on letterhead, to be submitted with this application. Application completed by a doctor must be an original.**

PLEASE PRINT

Name of Physician: _____ License #:_____

Address: _____ Telephone #:_____

Name of Disabled Person: _____

MEDICAL CERTIFICATION: This section must be completed by a Medical Doctor, Doctor of Osteopathy, physician assistant, nurse practitioner or podiatrist.(severe disability of the foot only) Please indicate below the disabling condition which necessitates that the above named applicant be granted a disabled parking permit; thereby entitling the individual to special parking privileges. INDICATE IF THIS CONDITION IS PERMANENT OR TEMPORARY, AND DESCRIBE THE LIMITATIONS WHICH CAUSE DIFFICULTY IN AMBULATION.

DIAGNOSIS: _____

(PLEASE PRINT OR TYPE – DO NOT ABBREVIATE OR USE OFFICE CODES)

IN REFERENCE TO AMBULATION, HOW IS THE APPLICANT AFFECTED BY THIS DIAGNOSIS?

_____

_____

Please certify if the patient's disability is permanent or temporary:

☐ Permanent ☐ Temporary & Expected Recovery Date

TEMPORARY DISABILITY: A temporarily disabled person is any person who is unable to ambulate without the aid of an assisting device, such as a brace, cane, crutch, prosthetic device, another person, wheelchair, walker or other assistive device. **Temporary permits are issued for periods of six months or less.**

PERMANENT DISABILITY: A "severely disabled person" is any person with one or more of the PERMANENT impairments, disabilities or conditions listed below, which limit mobility. (Check all that apply)

- ☐ Uses portable oxygen.
- ☐ Legally blind.
- ☐ Limited or no use of one or both legs.
- ☐ Unable to walk 200 ft. without stopping.
- ☐ Neuromuscular dysfunction that severely limits mobility
- ☐ Class III or IV cardiac condition (American Heart Assoc. Standards)
- ☐ Severely limited in ability to walk due to an arthritic, neurological or orthopedic condition.
- ☐ Restricted by lung disease to such an extent that forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter, or the arterial oxygen tension is less than sixty mm/hg of room air at rest.
- ☐ Has a physical or mental impairment or condition not listed above which constitutes an equal degree of disability, and which imposes unusual hardship in the use of public transportation and prevents the person from getting around without great difficulty?

SIGNATURE OF PHYSICIAN: _____ DATE: _____

(SIGNATURE STAMP NOT ACCEPTABLE)